Written Statement to Human Resources Sub-Committee

of the House Committee on Ways and Means[1]

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[1] These remarks are based on a scholarly literature review: Wetzler, S., Schwartz, B, Swanson, A. & Cahill, R. Substance Use Disorders and Employability Among Welfare Recipients, *Substance Use & Misuse*, 45:2095-2112, 2010. The remarks represent the views of Dr. Wetzler and do not necessarily represent the views of Montefiore Medical Center, University Behavioral Associates, or the Albert Einstein College of Medicine.

Thank you for the opportunity to discuss with you the issue of substance abuse with regard to welfare reform. I run several programs in Bronx, NY for welfare recipients, including a Supporting Healthy Marriage program and a program where welfare recipients with substance use disorders are evaluated, referred for treatment, and then offered case management services to help them comply with treatment and become employable. As you know, individuals can be exempted from the work participation requirements of the welfare law in order to participate in substance abuse treatment for a maximum of 4 consecutive weeks and a total of 6 weeks per year. Our program does a clinical evaluation to determine the level of care these substance abusers require, and whether they should be temporarily exempted from the work requirement in order to pursue intensive treatment, which is defined as greater than 15 hours per week. While our program works primarily with a General Assistance population, the nature of their substance abuse problems is similar to that found in the TANF population.

We find that over 70% of the over 20,000 substance abusers we have evaluated are employable at the time of applying for cash assistance, meaning that they are referred for non-intensive substance abuse treatment (less than 15 hours per week) concomitant with a referral to an employment program. In other words, they can work and get treatment simultaneously. In another 20% of cases, clients are referred for intensive treatment, and then re-evaluated, at which time they are deemed clinically stable enough to be employable and their frequency of treatment services is reduced to a non-intensive level. Thus, 90% of substance abusers in a welfare setting in the Bronx -- a locality that has one of the highest rates of substance abuse in the nation -- are sufficiently employable to meet the work participation requirements of the law.

This is an important statistic because at the time the law was drafted, the conventional wisdom in the substance abuse treatment world had been that these clients were not employable, needed to focus single-mindedly on their treatment, and would relapse if subjected to the stress of work demands.

We have found just the opposite: most substance abusers applying for or on welfare are employable, and work facilitates their recovery.

Although the majority of our clients are deemed employable, according to unemployment insurance (UI) data, only about 37% of them obtain competitive employment within 6 months of participating in our program. Since many clients obtain "off-the-books" jobs that are not documented and would not be reported in UI databases, we believe that a more accurate estimate of the number of our substance abuse clients who obtain employment within 6 months is at least 50%. Job retention is quite good, and very few of our employed clients re-cycle back onto cash assistance. Another 5-10% of our clients are considered permanently disabled due to a medical and/or psychiatric condition (substance abuse by itself is not considered a disabling condition), and are awarded Supplementary Security Income (SSI) or Social Security Disability Insurance benefits (SSDI). The remaining clients sooner or later have an administrative exit from cash assistance due to non-compliance with work or treatment requirements. Many of them ultimately cycle back onto cash assistance at a later date.

One of the implications of the welfare law is that it mandates clients into treatment: if they do not comply with the treatment requirements, they will lose their cash assistance. Although this mandate does not have much clout, meaning that the threatened punishment of losing cash assistance is not severe (in comparison to parole- or employer-

mandated treatment, where the negative consequences of not attending treatment are much more serious), it does enhance the person's motivation. While many people think that individuals need to be motivated so that they voluntarily choose to go to treatment, in fact coercive treatments are remarkably effective.

There is an enormous literature demonstrating the effectiveness of substance abuse treatment, but treatment can only work if patients attend, and the mandate helps get these welfare recipients to attend. In a typical substance abuse treatment setting, compliance with treatment is very poor. Between half and two-thirds of all patients drop out of treatment within 3 months of enrolling. There may have been a moment in time when they were motivated for treatment, which is why they enrolled, but that motivation waxes and wanes. With the support and guidance of our case managers and threatened loss of cash assistance, we are able to keep 81% of our clients engaged in treatment for at least 3 months. This is a remarkably high rate of treatment compliance for this population. We were the subject of two studies, one by the social policy research firm, MDRC, and another by CASA, the Columbia University Substance Abuse Research team, and both found that our case management program had a significant impact on treatment compliance in this hard-to-engage population. Other case management programs for substance abusers have corroborated this finding. Welfare recipients receiving case management are more likely to enroll in treatment, attend many more treatment appointments, and have higher rates of drug abstinence than substance abusing welfare recipients who are not in case management.

So, what do we know about substance abuse and welfare? First, although substance use is fairly prevalent in the welfare population, clinically diagnosable

substance use disorders are uncommon. Surveys, as well as drug testing, suggest that as many as 37% of welfare recipients use substances, however only 6-12% are screened as having a substance use problem at the welfare offices. These figures may be shifting as the welfare population shrinks: 10 years ago, 6% of the welfare population in NYC had an identified substance use disorder, whereas today that figure is 12%. This rate may be higher in NY than other localities as NY includes the General Assistance population (mostly older single males), which is more likely to have substance abuse problems than a TANF population.

Although people are screened for substance abuse problems at the time of application for cash assistance, it is essentially a process of self-identification – the screening consists of a few straightforward generic questions by the worker to all applicants at the site of enrollment. Once people are identified in this way, they are sent to our program for a thorough clinical substance abuse evaluation. Although this system does miss individuals who do not want to acknowledge their problem, if the substance abuse is severe enough to interfere with work functioning, it will become evident at a later date.

Second, just because someone has a substance use disorder does not mean that he or she is not employable. The vast majority of substance abusers are employable within the time frames laid out in the welfare law, and a longer period of intensive treatment is generally not necessary. The level of employability found among substance abusing welfare recipients suggest that high expectations regarding work are achievable.

We have found that work complements treatment; it provides structure, a high level of activity and absorption in tasks, as well as improved self-esteem and social skills.

Most importantly, work challenges the culture of dependency. Even for those clients who do require a period of intensive treatment, clinical gains can be quickly consolidated and they can be stepped down into non-intensive treatment and engaged in a concurrent work activity.

I am in favor of a "work early," if not a rigid "work first" approach. The challenge is coordinating the schedule for treatment and employment activities since they are provided by separate organizations, and both activities are mandatory.

Although substance abusers are employable, they have slightly poorer work outcomes than the general welfare population. This is not solely due to the substance use disorder, but to the many other associated barriers to employment, including co-morbid medical and psychiatric disorders, low literacy levels, lack of marketable job skills, and criminal justice histories. This configuration of problems means that the substance abusing welfare population is heterogeneous. We have found that an individualized case management approach is quite effective at engaging them. I've been very impressed with NYC Human Resources Administration's system of "customized assistance," which addresses these multiple needs.

Third, substance abuse is a chronic, relapsing disorder, and substance abusers on cash assistance typically have longstanding disorders, with many episodes of inpatient detoxification. One of the benefits of the welfare law is that the treatment mandate improves outpatient treatment compliance. Treatment works, and anything that gets patients "in the door" is significant.

We don't know much about what happens to non-compliant clients because they are administratively removed from cash assistance. Some re-cycle back onto cash

assistance, while others don't. In particular, we don't know whether an even longer period of treatment for these clients at this time would have resulted in more employment, but I doubt it.

Fourth, what is the role of drug testing? I can't speak to the issue of the legality of drug testing to determine eligibility for benefits or even the practicality of administering it to a large population, but I am a strong advocate for the use of drug testing in the context of treatment. Drug testing either involves urine specimens which are relatively inexpensive but somewhat difficult to obtain, or oral swabs which are easy to obtain but more expensive. Using either test, the results serve to corroborate or contradict the clients' claims that they are abstinent, and help to determine the extent of the disorder and the level of care that is needed. Treatment programs regularly and frequently require drug tests. So those people who we refer for treatment do not need to be drug tested at our evaluation site as they will be drug tested as soon as they enroll at the treatment program. Our evaluation program limits drug testing only to those people who claim to be clean and would not therefore be referred for treatment, and thus would not otherwise get drug tested. Before we agree that the person does not need treatment, we require objective proof of this claim, which the drug test results supply.

In NYC, the Human Resources Administration has treatment program standards that require treatment providers to re-consider the level and kind of treatment required when patients still have positive drug tests after a few months in treatment. When conducted in this way, in the context of treatment, drug testing is not punitive, nor is it an invasion of privacy. It is an integral part of planning the patient's treatment. I'm not sure how practical it is to screen all welfare recipients because it is inefficient, but it is very

useful for a substance abuse evaluation program such as ours to conduct drug testing when there is a suspicion of substance abuse, either by history or by observing behavior at the employment program. I can imagine its being expanded to certain high-risk populations -- i.e. clients in sanction – in order to determine need for treatment, but not to all applicants. One of the ramifications of expanding drug testing to the entire welfare population would be that so many people would be identified that the treatment system would not have sufficient capacity to handle the referrals.

Finally, while the Committee is focusing primarily on TANF, where substance abuse treatment is a condition for cash assistance, this is an even bigger issue with regard to Medicaid. As you know, the Medicaid population dwarfs the cash assistance population. In NYC, there are at least 8 times as many substance abusers on Medicaid as on cash assistance, and yet there are no requirements or treatment mandates for these individuals. Their care is completely unmanaged. Not only does this result in poor compliance and worse outcomes, it is enormously expensive. You might think that non-compliance with treatment saves Medicaid dollars, but in fact it leads to repeated episodes of inpatient detoxification which is much more expensive. There is a famous case of one man who lives in the Bronx who had 270 days of inpatient detoxification in one year and 272 days the following year. No one was managing his care, and he was free to go where he wanted. Unfortunately, he never went for outpatient treatment.

As a result of these high cost patients, NY established a way of tracking Medicaid expenses, and the substance abusers in our program are among the highest cost patients in the nation. They have very high substance abuse treatment costs, but they have even higher medical costs because they use the health care system so inefficiently. As states

try to redesign their Medicaid systems, they need to address these high-cost individuals, most of whom are substance abusers. One of the ancillary benefits of the welfare law's treatment mandate is that by keeping these people engaged in outpatient treatment, we are able to significantly reduce total health care costs. Based on an examination of Medicaid claims, we know that our program consistently achieves over 60% reduction in Medicaid costs as compared to the pre-enrollment year.

Unfortunately, funded through the welfare system, our program is restricted to cash assistance recipients. How can this be expanded to the Medicaid-only population? I don't see why participation in this kind of substance abuse care management program shouldn't be required for all Medicaid patients who have been screened for a substance use disorder in any medical setting. State agencies should also be permitted to identify potential substance abusers based on a review Medicaid records. Medicaid may be an entitlement, but it should also entail certain responsibilities, much like the welfare benefit does. This approach will not only reduce costs, it will improve compliance and outcomes.

Thank you.